


Students may test National Registry prior to completing the required 10 patient contacts by utilizing this packet and submitting it to WVOEMS. This education relief may ONLY be utilized during the COVID-19 policy modification and only applies to EMT courses ending prior to July 1, 2020. Submit to: Jerry.L.Mullins@wv.gov

PATIENT
CONTACT

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EMT Student Patient Assessment Documentation Form

	Student Name:		WVOEMS #		Shift Date:	
	Preceptor Name:		WVOEMS #		Location:	
Course Instructor Name:			Started Shift:		Ended Shift:	
Chief Complaint:						
DISPATCH		RACE		SCENE SURVEY		
<input type="checkbox"/> Non Emergency	<input type="checkbox"/> African American	<input type="checkbox"/> Scene Safe	<input type="checkbox"/> Drowning			
<input type="checkbox"/> Emergency	<input type="checkbox"/> American Indian	<input type="checkbox"/> Hazardous Materials	<input type="checkbox"/> Explosion			
GENDER	<input type="checkbox"/> Asian	<input type="checkbox"/> Violence	<input type="checkbox"/> Other:			
<input type="checkbox"/> Male	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Traffic				
<input type="checkbox"/> Female	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Weather				
AGE:	<input type="checkbox"/> Other	<input type="checkbox"/> Electrical				
MECHANISM OF INJURY		NATURE OF ILLNESS		ASSISTANCE REQUIRED		PATIENT CONDITION
<input type="checkbox"/> MVA	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Seizure	<input type="checkbox"/> Additional EMS	<input type="checkbox"/> Stable		
<input type="checkbox"/> Pedestrian Struck	<input type="checkbox"/> GI	<input type="checkbox"/> OB / GYN	<input type="checkbox"/> Rescue / FD	<input type="checkbox"/> Unstable		
<input type="checkbox"/> Fall	<input type="checkbox"/> GU	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Potentially Unstable		
<input type="checkbox"/> Blunt Trauma	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Environmental	<input type="checkbox"/> Mutual Aid	<input type="checkbox"/> Critical		
<input type="checkbox"/> Penetrating Trauma	<input type="checkbox"/> Stroke / CVA	<input type="checkbox"/> Other:	<input type="checkbox"/> Aeromedical	<input type="checkbox"/> Full Arrest		
<input type="checkbox"/> Burn	<input type="checkbox"/> Poison / OD		<input type="checkbox"/> Extrication	<input type="checkbox"/> DOS		
<input type="checkbox"/> Other:	<input type="checkbox"/> Anaphylaxis		<input type="checkbox"/> Other:			
PRIMARY PATIENT ASSESSMENT						
LOC		AIRWAY		BREATHING		CIRCULATION
<input type="checkbox"/> Alert	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	Color:	
<input type="checkbox"/> Oriented X3	<input type="checkbox"/> Adjunct (OPA)	<input type="checkbox"/> Labored	<input type="checkbox"/> Irregular	<input type="checkbox"/> Irregular	Temperature:	
<input type="checkbox"/> Verbal	<input type="checkbox"/> Combitube	<input type="checkbox"/> Irregular	<input type="checkbox"/> Bounding / Weak	<input type="checkbox"/> Bounding / Weak	Condition:	
<input type="checkbox"/> Pain	<input type="checkbox"/> King Airway	<input type="checkbox"/> Deep / Shallow	<input type="checkbox"/> Rapid / Shallow	<input type="checkbox"/> Rapid / Shallow	Cap Refill UE: _____ Sec.	
<input type="checkbox"/> Unresponsive	<input type="checkbox"/> Intubation	<input type="checkbox"/> Rapid / Slow	<input type="checkbox"/> Absent Carotid/Radial	<input type="checkbox"/> Absent Carotid/Radial	Cap Refill LE: _____ Sec.	
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	
FOCUSED HISTORY AND PHYSICAL EXAM						
HEAD		NECK		CHEST		ABDOMIN
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	
<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	
<input type="checkbox"/> Fluid Nose/Ears/Mouth	<input type="checkbox"/> Tracheal Deviation	<input type="checkbox"/> BS R Diminished / Absent	<input type="checkbox"/> BS R Diminished / Absent	<input type="checkbox"/> BS R Diminished / Absent	<input type="checkbox"/> Tender RU / LU / RL / LL	
<input type="checkbox"/> R Pupil Dil / Const	<input type="checkbox"/> JVD	<input type="checkbox"/> BS L Diminished / Absent	<input type="checkbox"/> BS L Diminished / Absent	<input type="checkbox"/> BS L Diminished / Absent	<input type="checkbox"/> Rigid	
<input type="checkbox"/> L Pupil Dil / Const		<input type="checkbox"/> Crackles / Rales / Wheezes	<input type="checkbox"/> Crackles / Rales / Wheezes	<input type="checkbox"/> Crackles / Rales / Wheezes	<input type="checkbox"/>	
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	
PELVIS		LOWER EXTREMITIES		UPPER EXTREMITIES		BACK
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	
<input type="checkbox"/> DCAP-BTLS	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS	
<input type="checkbox"/> Crepitus	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/>	
<input type="checkbox"/> Unstable	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	
CRITICAL INTERVENTIONS						
<input type="checkbox"/> Maintain Airway	<input type="checkbox"/> Suctioning	<input type="checkbox"/> APGAR				
<input type="checkbox"/> Spinal Immobilization	<input type="checkbox"/> Breathing Treatment	<input type="checkbox"/> Glasco Coma Scale				
<input type="checkbox"/> Ventilation	<input type="checkbox"/> Pulse Ox	<input type="checkbox"/> Oxygen LPM _____ / Delivery Device _____				
<input type="checkbox"/> Control Bleeding	<input type="checkbox"/> Glucometer Reading	<input type="checkbox"/>				
<input type="checkbox"/> CPR / Defibrillation	<input type="checkbox"/> Temperature	<input type="checkbox"/>				
<input type="checkbox"/> Other:						

WEST VIRGINIA OFFICE OF EMERGENCY MEDICAL SERVICES
EMT Student Patient Assessment Documentation Form


[illegible]

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PATIENT
CONTACT

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EMT Student Patient Assessment Documentation Form

	Student Name:		WVOEMS #		Shift Date:	
	Preceptor Name:		WVOEMS #		Location:	
Course Instructor Name:			Started Shift:		Ended Shift:	
Chief Complaint:						
DISPATCH		RACE		SCENE SURVEY		
<input type="checkbox"/> Non Emergency	<input type="checkbox"/> African American	<input type="checkbox"/> Scene Safe	<input type="checkbox"/> Drowning			
<input type="checkbox"/> Emergency	<input type="checkbox"/> American Indian	<input type="checkbox"/> Hazardous Materials	<input type="checkbox"/> Explosion			
GENDER	<input type="checkbox"/> Asian	<input type="checkbox"/> Violence	<input type="checkbox"/> Other:			
<input type="checkbox"/> Male	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Traffic				
<input type="checkbox"/> Female	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Weather				
AGE:	<input type="checkbox"/> Other	<input type="checkbox"/> Electrical				
MECHANISM OF INJURY		NATURE OF ILLNESS		ASSISTANCE REQUIRED		PATIENT CONDITION
<input type="checkbox"/> MVA	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Seizure	<input type="checkbox"/> Additional EMS	<input type="checkbox"/> Stable		
<input type="checkbox"/> Pedestrian Struck	<input type="checkbox"/> GI	<input type="checkbox"/> OB / GYN	<input type="checkbox"/> Rescue / FD	<input type="checkbox"/> Unstable		
<input type="checkbox"/> Fall	<input type="checkbox"/> GU	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Potentially Unstable		
<input type="checkbox"/> Blunt Trauma	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Environmental	<input type="checkbox"/> Mutual Aid	<input type="checkbox"/> Critical		
<input type="checkbox"/> Penetrating Trauma	<input type="checkbox"/> Stroke / CVA	<input type="checkbox"/> Other:	<input type="checkbox"/> Aeromedical	<input type="checkbox"/> Full Arrest		
<input type="checkbox"/> Burn	<input type="checkbox"/> Poison / OD		<input type="checkbox"/> Extrication	<input type="checkbox"/> DOS		
<input type="checkbox"/> Other:	<input type="checkbox"/> Anaphylaxis		<input type="checkbox"/> Other:			
PRIMARY PATIENT ASSESSMENT						
LOC	AIRWAY	BREATHING	CIRCULATION	SKIN CONDITION		
<input type="checkbox"/> Alert	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	Color:		
<input type="checkbox"/> Oriented X3	<input type="checkbox"/> Adjunct (OPA)	<input type="checkbox"/> Labored	<input type="checkbox"/> Irregular	Temperature:		
<input type="checkbox"/> Verbal	<input type="checkbox"/> Combitube	<input type="checkbox"/> Irregular	<input type="checkbox"/> Bounding / Weak	Condition:		
<input type="checkbox"/> Pain	<input type="checkbox"/> King Airway	<input type="checkbox"/> Deep / Shallow	<input type="checkbox"/> Rapid / Shallow	Cap Refill UE: _____ Sec.		
<input type="checkbox"/> Unresponsive	<input type="checkbox"/> Intubation	<input type="checkbox"/> Rapid / Slow	<input type="checkbox"/> Absent Carotid/Radial	Cap Refill LE: _____ Sec.		
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:		
FOCUSED HISTORY AND PHYSICAL EXAM						
HEAD		NECK		CHEST		ABDOMIN
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal		
<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS		
<input type="checkbox"/> Fluid Nose/Ears/Mouth	<input type="checkbox"/> Tracheal Deviation	<input type="checkbox"/> BS R Diminished / Absent	<input type="checkbox"/> BS L Diminished / Absent	<input type="checkbox"/> Tender RU / LU / RL / LL		
<input type="checkbox"/> R Pupil Dil / Const	<input type="checkbox"/> JVD	<input type="checkbox"/> Crackles / Rales / Wheezes	<input type="checkbox"/> Rigid			
<input type="checkbox"/> L Pupil Dil / Const		<input type="checkbox"/> Other:	<input type="checkbox"/> Other:			
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:			
PELVIS		LOWER EXTREMITIES		UPPER EXTREMITIES		BACK
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal		
<input type="checkbox"/> DCAP-BTLS	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS		
<input type="checkbox"/> Crepitus	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/>		
<input type="checkbox"/> Unstable	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:		
CRITICAL INTERVENTIONS						
<input type="checkbox"/> Maintain Airway	<input type="checkbox"/> Suctioning	<input type="checkbox"/> APGAR				
<input type="checkbox"/> Spinal Immobilization	<input type="checkbox"/> Breathing Treatment	<input type="checkbox"/> Glasco Coma Scale				
<input type="checkbox"/> Ventilation	<input type="checkbox"/> Pulse Ox	<input type="checkbox"/> Oxygen LPM _____ / Delivery Device _____				
<input type="checkbox"/> Control Bleeding	<input type="checkbox"/> Glucometer Reading	<input type="checkbox"/>				
<input type="checkbox"/> CPR / Defibrillation	<input type="checkbox"/> Temperature	<input type="checkbox"/>				
<input type="checkbox"/> Other:						

WEST VIRGINIA OFFICE OF EMERGENCY MEDICAL SERVICES
EMT Student Patient Assessment Documentation Form


[illegible]

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PATIENT
CONTACT

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EMT Student Patient Assessment Documentation Form

	Student Name:		WVOEMS #		Shift Date:	
	Preceptor Name:		WVOEMS #		Location:	
Course Instructor Name:			Started Shift:		Ended Shift:	
Chief Complaint:						
DISPATCH		RACE		SCENE SURVEY		
<input type="checkbox"/> Non Emergency	<input type="checkbox"/> African American	<input type="checkbox"/> Scene Safe	<input type="checkbox"/> Drowning			
<input type="checkbox"/> Emergency	<input type="checkbox"/> American Indian	<input type="checkbox"/> Hazardous Materials	<input type="checkbox"/> Explosion			
GENDER	<input type="checkbox"/> Asian	<input type="checkbox"/> Violence	<input type="checkbox"/> Other:			
<input type="checkbox"/> Male	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Traffic				
<input type="checkbox"/> Female	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Weather				
AGE:	<input type="checkbox"/> Other	<input type="checkbox"/> Electrical				
MECHANISM OF INJURY		NATURE OF ILLNESS		ASSISTANCE REQUIRED		PATIENT CONDITION
<input type="checkbox"/> MVA	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Seizure	<input type="checkbox"/> Additional EMS	<input type="checkbox"/> Stable		
<input type="checkbox"/> Pedestrian Struck	<input type="checkbox"/> GI	<input type="checkbox"/> OB / GYN	<input type="checkbox"/> Rescue / FD	<input type="checkbox"/> Unstable		
<input type="checkbox"/> Fall	<input type="checkbox"/> GU	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Potentially Unstable		
<input type="checkbox"/> Blunt Trauma	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Environmental	<input type="checkbox"/> Mutual Aid	<input type="checkbox"/> Critical		
<input type="checkbox"/> Penetrating Trauma	<input type="checkbox"/> Stroke / CVA	<input type="checkbox"/> Other:	<input type="checkbox"/> Aeromedical	<input type="checkbox"/> Full Arrest		
<input type="checkbox"/> Burn	<input type="checkbox"/> Poison / OD		<input type="checkbox"/> Extrication	<input type="checkbox"/> DOS		
<input type="checkbox"/> Other:	<input type="checkbox"/> Anaphylaxis		<input type="checkbox"/> Other:			
PRIMARY PATIENT ASSESSMENT						
LOC	AIRWAY	BREATHING	CIRCULATION	SKIN CONDITION		
<input type="checkbox"/> Alert	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	Color:		
<input type="checkbox"/> Oriented X3	<input type="checkbox"/> Adjunct (OPA)	<input type="checkbox"/> Labored	<input type="checkbox"/> Irregular	Temperature:		
<input type="checkbox"/> Verbal	<input type="checkbox"/> Combitube	<input type="checkbox"/> Irregular	<input type="checkbox"/> Bounding / Weak	Condition:		
<input type="checkbox"/> Pain	<input type="checkbox"/> King Airway	<input type="checkbox"/> Deep / Shallow	<input type="checkbox"/> Rapid / Shallow	Cap Refill UE: _____ Sec.		
<input type="checkbox"/> Unresponsive	<input type="checkbox"/> Intubation	<input type="checkbox"/> Rapid / Slow	<input type="checkbox"/> Absent Carotid/Radial	Cap Refill LE: _____ Sec.		
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:		
FOCUSED HISTORY AND PHYSICAL EXAM						
HEAD		NECK		CHEST		ABDOMIN
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal		
<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS		
<input type="checkbox"/> Fluid Nose/Ears/Mouth	<input type="checkbox"/> Tracheal Deviation	<input type="checkbox"/> BS R Diminished / Absent	<input type="checkbox"/> BS L Diminished / Absent	<input type="checkbox"/> Tender RU / LU / RL / LL		
<input type="checkbox"/> R Pupil Dil / Const	<input type="checkbox"/> JVD	<input type="checkbox"/> Crackles / Rales / Wheezes	<input type="checkbox"/> Rigid			
<input type="checkbox"/> L Pupil Dil / Const		<input type="checkbox"/> Other:	<input type="checkbox"/> Other:			
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:			
PELVIS		LOWER EXTREMITIES		UPPER EXTREMITIES		BACK
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal		
<input type="checkbox"/> DCAP-BTLS	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS		
<input type="checkbox"/> Crepitus	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left			
<input type="checkbox"/> Unstable	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/> PMS Deficit			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:		
CRITICAL INTERVENTIONS						
<input type="checkbox"/> Maintain Airway	<input type="checkbox"/> Suctioning	<input type="checkbox"/> APGAR				
<input type="checkbox"/> Spinal Immobilization	<input type="checkbox"/> Breathing Treatment	<input type="checkbox"/> Glasco Coma Scale				
<input type="checkbox"/> Ventilation	<input type="checkbox"/> Pulse Ox	<input type="checkbox"/> Oxygen LPM _____ / Delivery Device _____				
<input type="checkbox"/> Control Bleeding	<input type="checkbox"/> Glucometer Reading					
<input type="checkbox"/> CPR / Defibrillation	<input type="checkbox"/> Temperature					
<input type="checkbox"/> Other:						

WEST VIRGINIA OFFICE OF EMERGENCY MEDICAL SERVICES
EMT Student Patient Assessment Documentation Form


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PATIENT
CONTACT

4

EMT Student Patient Assessment Documentation Form

	Student Name:		WVOEMS #		Shift Date:	
	Preceptor Name:		WVOEMS #		Location:	
Course Instructor Name:			Started Shift:		Ended Shift:	
Chief Complaint:						
DISPATCH		RACE		SCENE SURVEY		
<input type="checkbox"/> Non Emergency	<input type="checkbox"/> African American	<input type="checkbox"/> Scene Safe	<input type="checkbox"/> Drowning			
<input type="checkbox"/> Emergency	<input type="checkbox"/> American Indian	<input type="checkbox"/> Hazardous Materials	<input type="checkbox"/> Explosion			
GENDER	<input type="checkbox"/> Asian	<input type="checkbox"/> Violence	<input type="checkbox"/> Other:			
<input type="checkbox"/> Male	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Traffic				
<input type="checkbox"/> Female	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Weather				
AGE:	<input type="checkbox"/> Other	<input type="checkbox"/> Electrical				
MECHANISM OF INJURY		NATURE OF ILLNESS		ASSISTANCE REQUIRED		PATIENT CONDITION
<input type="checkbox"/> MVA	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Seizure	<input type="checkbox"/> Additional EMS	<input type="checkbox"/> Stable		
<input type="checkbox"/> Pedestrian Struck	<input type="checkbox"/> GI	<input type="checkbox"/> OB / GYN	<input type="checkbox"/> Rescue / FD	<input type="checkbox"/> Unstable		
<input type="checkbox"/> Fall	<input type="checkbox"/> GU	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Potentially Unstable		
<input type="checkbox"/> Blunt Trauma	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Environmental	<input type="checkbox"/> Mutual Aid	<input type="checkbox"/> Critical		
<input type="checkbox"/> Penetrating Trauma	<input type="checkbox"/> Stroke / CVA	<input type="checkbox"/> Other:	<input type="checkbox"/> Aeromedical	<input type="checkbox"/> Full Arrest		
<input type="checkbox"/> Burn	<input type="checkbox"/> Poison / OD		<input type="checkbox"/> Extrication	<input type="checkbox"/> DOS		
<input type="checkbox"/> Other:	<input type="checkbox"/> Anaphylaxis		<input type="checkbox"/> Other:			
PRIMARY PATIENT ASSESSMENT						
LOC	AIRWAY	BREATHING	CIRCULATION	SKIN CONDITION		
<input type="checkbox"/> Alert	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	Color:		
<input type="checkbox"/> Oriented X3	<input type="checkbox"/> Adjunct (OPA)	<input type="checkbox"/> Labored	<input type="checkbox"/> Irregular	Temperature:		
<input type="checkbox"/> Verbal	<input type="checkbox"/> Combitube	<input type="checkbox"/> Irregular	<input type="checkbox"/> Bounding / Weak	Condition:		
<input type="checkbox"/> Pain	<input type="checkbox"/> King Airway	<input type="checkbox"/> Deep / Shallow	<input type="checkbox"/> Rapid / Shallow	Cap Refill UE: _____ Sec.		
<input type="checkbox"/> Unresponsive	<input type="checkbox"/> Intubation	<input type="checkbox"/> Rapid / Slow	<input type="checkbox"/> Absent Carotid/Radial	Cap Refill LE: _____ Sec.		
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:		
FOCUSED HISTORY AND PHYSICAL EXAM						
HEAD		NECK		CHEST		ABDOMIN
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal		
<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS		
<input type="checkbox"/> Fluid Nose/Ears/Mouth	<input type="checkbox"/> Tracheal Deviation	<input type="checkbox"/> BS R Diminished / Absent	<input type="checkbox"/> BS L Diminished / Absent	<input type="checkbox"/> Tender RU / LU / RL / LL		
<input type="checkbox"/> R Pupil Dil / Const	<input type="checkbox"/> JVD	<input type="checkbox"/> Crackles / Rales / Wheezes	<input type="checkbox"/> Rigid			
<input type="checkbox"/> L Pupil Dil / Const		<input type="checkbox"/> Other:	<input type="checkbox"/> Other:			
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:			
PELVIS		LOWER EXTREMITIES		UPPER EXTREMITIES		BACK
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal		
<input type="checkbox"/> DCAP-BTLS	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS		
<input type="checkbox"/> Crepitus	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/>		
<input type="checkbox"/> Unstable	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:		
CRITICAL INTERVENTIONS						
<input type="checkbox"/> Maintain Airway	<input type="checkbox"/> Suctioning	<input type="checkbox"/> APGAR				
<input type="checkbox"/> Spinal Immobilization	<input type="checkbox"/> Breathing Treatment	<input type="checkbox"/> Glasco Coma Scale				
<input type="checkbox"/> Ventilation	<input type="checkbox"/> Pulse Ox	<input type="checkbox"/> Oxygen LPM _____ / Delivery Device _____				
<input type="checkbox"/> Control Bleeding	<input type="checkbox"/> Glucometer Reading	<input type="checkbox"/>				
<input type="checkbox"/> CPR / Defibrillation	<input type="checkbox"/> Temperature	<input type="checkbox"/>				
<input type="checkbox"/> Other:						

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[illegible]

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PATIENT
CONTACT

5

EMT Student Patient Assessment Documentation Form

	Student Name:	WVOEMS #	Shift Date:
	Preceptor Name:	WVOEMS #	Location:
Course Instructor Name:		Started Shift:	Ended Shift:
Chief Complaint:			
DISPATCH		RACE	
<input type="checkbox"/> Non Emergency	<input type="checkbox"/> African American	<input type="checkbox"/> Scene Safe	<input type="checkbox"/> Drowning
<input type="checkbox"/> Emergency	<input type="checkbox"/> American Indian	<input type="checkbox"/> Hazardous Materials	<input type="checkbox"/> Explosion
GENDER		<input type="checkbox"/> Violence	<input type="checkbox"/> Other:
<input type="checkbox"/> Male	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Traffic	
<input type="checkbox"/> Female	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Weather	
AGE:	<input type="checkbox"/> Other	<input type="checkbox"/> Electrical	
MECHANISM OF INJURY		NATURE OF ILLNESS	
<input type="checkbox"/> MVA	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Seizure	<input type="checkbox"/> Additional EMS
<input type="checkbox"/> Pedestrian Struck	<input type="checkbox"/> GI	<input type="checkbox"/> OB / GYN	<input type="checkbox"/> Rescue / FD
<input type="checkbox"/> Fall	<input type="checkbox"/> GU	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Law Enforcement
<input type="checkbox"/> Blunt Trauma	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Environmental	<input type="checkbox"/> Mutual Aid
<input type="checkbox"/> Penetrating Trauma	<input type="checkbox"/> Stroke / CVA	<input type="checkbox"/> Other:	<input type="checkbox"/> Aeromedical
<input type="checkbox"/> Burn	<input type="checkbox"/> Poison / OD	<input type="checkbox"/> Extrication	<input type="checkbox"/> DOS
<input type="checkbox"/> Other:	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Other:	
PRIMARY PATIENT ASSESSMENT			
LOC		AIRWAY	
<input type="checkbox"/> Alert	<input type="checkbox"/> Normal	<input type="checkbox"/> Breathing	<input type="checkbox"/> Circulation
<input type="checkbox"/> Oriented X3	<input type="checkbox"/> Adjunct (OPA)	<input type="checkbox"/> Labored	<input type="checkbox"/> Irregular
<input type="checkbox"/> Verbal	<input type="checkbox"/> Combitube	<input type="checkbox"/> Irregular	<input type="checkbox"/> Bounding / Weak
<input type="checkbox"/> Pain	<input type="checkbox"/> King Airway	<input type="checkbox"/> Deep / Shallow	<input type="checkbox"/> Rapid / Shallow
<input type="checkbox"/> Unresponsive	<input type="checkbox"/> Intubation	<input type="checkbox"/> Rapid / Slow	<input type="checkbox"/> Absent Carotid/Radial
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
FOCUSED HISTORY AND PHYSICAL EXAM			
HEAD		NECK	
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Chest	<input type="checkbox"/> Abdomin
<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS
<input type="checkbox"/> Fluid Nose/Ears/Mouth	<input type="checkbox"/> Tracheal Deviation	<input type="checkbox"/> BS R Diminished / Absent	<input type="checkbox"/> Tender RU / LU / RL / LL
<input type="checkbox"/> R Pupil Dil / Const	<input type="checkbox"/> JVD	<input type="checkbox"/> BS L Diminished / Absent	<input type="checkbox"/> Rigid
<input type="checkbox"/> L Pupil Dil / Const	<input type="checkbox"/>	<input type="checkbox"/> Crackles / Rales / Wheezes	<input type="checkbox"/>
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
PELVIS		LOWER EXTREMITIES	
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> UPPER EXTREMITIES	<input type="checkbox"/> BACK
<input type="checkbox"/> DCAP-BTLS	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS
<input type="checkbox"/> Crepitus	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/>
<input type="checkbox"/> Unstable	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
CRITICAL INTERVENTIONS			
<input type="checkbox"/> Maintain Airway	<input type="checkbox"/> Suctioning	<input type="checkbox"/> APGAR	
<input type="checkbox"/> Spinal Immobilization	<input type="checkbox"/> Breathing Treatment	<input type="checkbox"/> Glasco Coma Scale	
<input type="checkbox"/> Ventilation	<input type="checkbox"/> Pulse Ox	<input type="checkbox"/> Oxygen LPM _____ / Delivery Device _____	
<input type="checkbox"/> Control Bleeding	<input type="checkbox"/> Glucometer Reading	<input type="checkbox"/>	
<input type="checkbox"/> CPR / Defibrillation	<input type="checkbox"/> Temperature	<input type="checkbox"/>	
<input type="checkbox"/> Other:			

WEST VIRGINIA OFFICE OF EMERGENCY MEDICAL SERVICES
EMT Student Patient Assessment Documentation Form


[illegible]

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PATIENT
CONTACT

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EMT Student Patient Assessment Documentation Form

	Student Name:		WVOEMS #		Shift Date:	
	Preceptor Name:		WVOEMS #		Location:	
Course Instructor Name:			Started Shift:		Ended Shift:	
Chief Complaint:						
DISPATCH		RACE		SCENE SURVEY		
<input type="checkbox"/> Non Emergency	<input type="checkbox"/> African American	<input type="checkbox"/> Scene Safe	<input type="checkbox"/> Drowning			
<input type="checkbox"/> Emergency	<input type="checkbox"/> American Indian	<input type="checkbox"/> Hazardous Materials	<input type="checkbox"/> Explosion			
GENDER	<input type="checkbox"/> Asian	<input type="checkbox"/> Violence	<input type="checkbox"/> Other:			
<input type="checkbox"/> Male	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Traffic				
<input type="checkbox"/> Female	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Weather				
AGE:	<input type="checkbox"/> Other	<input type="checkbox"/> Electrical				
MECHANISM OF INJURY		NATURE OF ILLNESS		ASSISTANCE REQUIRED		PATIENT CONDITION
<input type="checkbox"/> MVA	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Seizure	<input type="checkbox"/> Additional EMS	<input type="checkbox"/> Stable		
<input type="checkbox"/> Pedestrian Struck	<input type="checkbox"/> GI	<input type="checkbox"/> OB / GYN	<input type="checkbox"/> Rescue / FD	<input type="checkbox"/> Unstable		
<input type="checkbox"/> Fall	<input type="checkbox"/> GU	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Potentially Unstable		
<input type="checkbox"/> Blunt Trauma	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Environmental	<input type="checkbox"/> Mutual Aid	<input type="checkbox"/> Critical		
<input type="checkbox"/> Penetrating Trauma	<input type="checkbox"/> Stroke / CVA	<input type="checkbox"/> Other:	<input type="checkbox"/> Aeromedical	<input type="checkbox"/> Full Arrest		
<input type="checkbox"/> Burn	<input type="checkbox"/> Poison / OD		<input type="checkbox"/> Extrication	<input type="checkbox"/> DOS		
<input type="checkbox"/> Other:	<input type="checkbox"/> Anaphylaxis		<input type="checkbox"/> Other:			
PRIMARY PATIENT ASSESSMENT						
LOC	AIRWAY	BREATHING	CIRCULATION	SKIN CONDITION		
<input type="checkbox"/> Alert	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	Color:		
<input type="checkbox"/> Oriented X3	<input type="checkbox"/> Adjunct (OPA)	<input type="checkbox"/> Labored	<input type="checkbox"/> Irregular	Temperature:		
<input type="checkbox"/> Verbal	<input type="checkbox"/> Combitube	<input type="checkbox"/> Irregular	<input type="checkbox"/> Bounding / Weak	Condition:		
<input type="checkbox"/> Pain	<input type="checkbox"/> King Airway	<input type="checkbox"/> Deep / Shallow	<input type="checkbox"/> Rapid / Shallow	Cap Refill UE: _____ Sec.		
<input type="checkbox"/> Unresponsive	<input type="checkbox"/> Intubation	<input type="checkbox"/> Rapid / Slow	<input type="checkbox"/> Absent Carotid/Radial	Cap Refill LE: _____ Sec.		
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:		
FOCUSED HISTORY AND PHYSICAL EXAM						
HEAD		NECK		CHEST		ABDOMIN
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal		
<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS		
<input type="checkbox"/> Fluid Nose/Ears/Mouth	<input type="checkbox"/> Tracheal Deviation	<input type="checkbox"/> BS R Diminished / Absent	<input type="checkbox"/> BS L Diminished / Absent	<input type="checkbox"/> Tender RU / LU / RL / LL		
<input type="checkbox"/> R Pupil Dil / Const	<input type="checkbox"/> JVD	<input type="checkbox"/> Crackles / Rales / Wheezes	<input type="checkbox"/> Rigid			
<input type="checkbox"/> L Pupil Dil / Const		<input type="checkbox"/> Other:	<input type="checkbox"/> Other:			
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:			
PELVIS		LOWER EXTREMITIES		UPPER EXTREMITIES		BACK
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal		
<input type="checkbox"/> DCAP-BTLS	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS		
<input type="checkbox"/> Crepitus	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left			
<input type="checkbox"/> Unstable	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/> PMS Deficit			
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:		
CRITICAL INTERVENTIONS						
<input type="checkbox"/> Maintain Airway	<input type="checkbox"/> Suctioning	<input type="checkbox"/> APGAR				
<input type="checkbox"/> Spinal Immobilization	<input type="checkbox"/> Breathing Treatment	<input type="checkbox"/> Glasco Coma Scale				
<input type="checkbox"/> Ventilation	<input type="checkbox"/> Pulse Ox	<input type="checkbox"/> Oxygen LPM _____ / Delivery Device _____				
<input type="checkbox"/> Control Bleeding	<input type="checkbox"/> Glucometer Reading					
<input type="checkbox"/> CPR / Defibrillation	<input type="checkbox"/> Temperature					
<input type="checkbox"/> Other:						

WEST VIRGINIA OFFICE OF EMERGENCY MEDICAL SERVICES
EMT Student Patient Assessment Documentation Form


[illegible]

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PATIENT
CONTACT

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EMT Student Patient Assessment Documentation Form

	Student Name:	WVOEMS #	Shift Date:
	Preceptor Name:	WVOEMS #	Location:
Course Instructor Name:		Started Shift:	Ended Shift:
Chief Complaint:			
DISPATCH		RACE	
<input type="checkbox"/> Non Emergency	<input type="checkbox"/> African American	<input type="checkbox"/> Scene Safe	
<input type="checkbox"/> Emergency	<input type="checkbox"/> American Indian	<input type="checkbox"/> Hazardous Materials	
GENDER	<input type="checkbox"/> Asian	<input type="checkbox"/> Violence	
<input type="checkbox"/> Male	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Traffic	
<input type="checkbox"/> Female	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Weather	
AGE:	<input type="checkbox"/> Other	<input type="checkbox"/> Electrical	
MECHANISM OF INJURY		NATURE OF ILLNESS	
<input type="checkbox"/> MVA	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Seizure	
<input type="checkbox"/> Pedestrian Struck	<input type="checkbox"/> GI	<input type="checkbox"/> OB / GYN	
<input type="checkbox"/> Fall	<input type="checkbox"/> GU	<input type="checkbox"/> Behavioral	
<input type="checkbox"/> Blunt Trauma	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Environmental	
<input type="checkbox"/> Penetrating Trauma	<input type="checkbox"/> Stroke / CVA	<input type="checkbox"/> Other:	
<input type="checkbox"/> Burn	<input type="checkbox"/> Poison / OD	<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Other:	
ASSISTANCE REQUIRED			
<input type="checkbox"/> Additional EMS		<input type="checkbox"/> Stable	
<input type="checkbox"/> Rescue / FD		<input type="checkbox"/> Unstable	
<input type="checkbox"/> Law Enforcement		<input type="checkbox"/> Potentially Unstable	
<input type="checkbox"/> Mutual Aid		<input type="checkbox"/> Critical	
<input type="checkbox"/> Aeromedical		<input type="checkbox"/> Full Arrest	
<input type="checkbox"/> Extrication		<input type="checkbox"/> DOS	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
PATIENT CONDITION			
PRIMARY PATIENT ASSESSMENT			
LOC	AIRWAY	BREATHING	CIRCULATION
<input type="checkbox"/> Alert	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal
<input type="checkbox"/> Oriented X3	<input type="checkbox"/> Adjunct (OPA)	<input type="checkbox"/> Labored	<input type="checkbox"/> Irregular
<input type="checkbox"/> Verbal	<input type="checkbox"/> Combitube	<input type="checkbox"/> Irregular	<input type="checkbox"/> Bounding / Weak
<input type="checkbox"/> Pain	<input type="checkbox"/> King Airway	<input type="checkbox"/> Deep / Shallow	<input type="checkbox"/> Rapid / Shallow
<input type="checkbox"/> Unresponsive	<input type="checkbox"/> Intubation	<input type="checkbox"/> Rapid / Slow	<input type="checkbox"/> Absent Carotid/Radial
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
FOCUSED HISTORY AND PHYSICAL EXAM			
HEAD	NECK	CHEST	ABDOMIN
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal
<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS
<input type="checkbox"/> Fluid Nose/Ears/Mouth	<input type="checkbox"/> Tracheal Deviation	<input type="checkbox"/> BS R Diminished / Absent	<input type="checkbox"/> Tender RU / LU / RL / LL
<input type="checkbox"/> R Pupil Dil / Const	<input type="checkbox"/> JVD	<input type="checkbox"/> BS L Diminished / Absent	<input type="checkbox"/> Rigid
<input type="checkbox"/> L Pupil Dil / Const	<input type="checkbox"/>	<input type="checkbox"/> Crackles / Rales / Wheezes	<input type="checkbox"/>
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
PELVIS	LOWER EXTREMITIES	UPPER EXTREMITIES	BACK
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal
<input type="checkbox"/> DCAP-BTLS	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS
<input type="checkbox"/> Crepitus	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/>
<input type="checkbox"/> Unstable	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
CRITICAL INTERVENTIONS			
<input type="checkbox"/> Maintain Airway	<input type="checkbox"/> Suctioning	<input type="checkbox"/> APGAR	
<input type="checkbox"/> Spinal Immobilization	<input type="checkbox"/> Breathing Treatment	<input type="checkbox"/> Glasco Coma Scale	
<input type="checkbox"/> Ventilation	<input type="checkbox"/> Pulse Ox	<input type="checkbox"/> Oxygen LPM _____ / Delivery Device _____	
<input type="checkbox"/> Control Bleeding	<input type="checkbox"/> Glucometer Reading	<input type="checkbox"/>	
<input type="checkbox"/> CPR / Defibrillation	<input type="checkbox"/> Temperature	<input type="checkbox"/>	
<input type="checkbox"/> Other:	<input type="checkbox"/>		

WEST VIRGINIA OFFICE OF EMERGENCY MEDICAL SERVICES
EMT Student Patient Assessment Documentation Form


[illegible]

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PATIENT
CONTACT

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EMT Student Patient Assessment Documentation Form

	Student Name:	WVOEMS #	Shift Date:
	Preceptor Name:	WVOEMS #	Location:
Course Instructor Name:		Started Shift:	Ended Shift:
Chief Complaint:			
DISPATCH		RACE	
<input type="checkbox"/> Non Emergency	<input type="checkbox"/> African American	<input type="checkbox"/> Scene Safe	
<input type="checkbox"/> Emergency	<input type="checkbox"/> American Indian	<input type="checkbox"/> Hazardous Materials	
GENDER		<input type="checkbox"/> Violence	
<input type="checkbox"/> Male	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Traffic	
<input type="checkbox"/> Female	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Weather	
AGE:	<input type="checkbox"/> Other	<input type="checkbox"/> Electrical	
MECHANISM OF INJURY		NATURE OF ILLNESS	
<input type="checkbox"/> MVA	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Seizure	
<input type="checkbox"/> Pedestrian Struck	<input type="checkbox"/> GI	<input type="checkbox"/> OB / GYN	
<input type="checkbox"/> Fall	<input type="checkbox"/> GU	<input type="checkbox"/> Behavioral	
<input type="checkbox"/> Blunt Trauma	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Environmental	
<input type="checkbox"/> Penetrating Trauma	<input type="checkbox"/> Stroke / CVA	<input type="checkbox"/> Other:	
<input type="checkbox"/> Burn	<input type="checkbox"/> Poison / OD	<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Other:	
ASSISTANCE REQUIRED			
<input type="checkbox"/> Additional EMS		<input type="checkbox"/> Stable	
<input type="checkbox"/> Rescue / FD		<input type="checkbox"/> Unstable	
<input type="checkbox"/> Law Enforcement		<input type="checkbox"/> Potentially Unstable	
<input type="checkbox"/> Mutual Aid		<input type="checkbox"/> Critical	
<input type="checkbox"/> Aeromedical		<input type="checkbox"/> Full Arrest	
<input type="checkbox"/> Extrication		<input type="checkbox"/> DOS	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
PATIENT CONDITION			
PRIMARY PATIENT ASSESSMENT			
LOC		AIRWAY	
<input type="checkbox"/> Alert	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	
<input type="checkbox"/> Oriented X3	<input type="checkbox"/> Adjunct (OPA)	<input type="checkbox"/> Labored	
<input type="checkbox"/> Verbal	<input type="checkbox"/> Combitube	<input type="checkbox"/> Irregular	
<input type="checkbox"/> Pain	<input type="checkbox"/> King Airway	<input type="checkbox"/> Deep / Shallow	
<input type="checkbox"/> Unresponsive	<input type="checkbox"/> Intubation	<input type="checkbox"/> Rapid / Slow	
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	
BREATHING		CIRCULATION	
<input type="checkbox"/> Normal		<input type="checkbox"/> Normal	
<input type="checkbox"/> Irregular		<input type="checkbox"/> Irregular	
<input type="checkbox"/> Bounding / Weak		<input type="checkbox"/> Bounding / Weak	
<input type="checkbox"/> Rapid / Shallow		<input type="checkbox"/> Rapid / Shallow	
<input type="checkbox"/> Absent Carotid/Radial		<input type="checkbox"/> Absent Carotid/Radial	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
SKIN CONDITION			
Color:			
Temperature:			
Condition:			
Cap Refill UE: _____ Sec.			
Cap Refill LE: _____ Sec.			
<input type="checkbox"/> Other:			
FOCUSED HISTORY AND PHYSICAL EXAM			
HEAD		NECK	
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	
<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	
<input type="checkbox"/> Fluid Nose/Ears/Mouth	<input type="checkbox"/> Tracheal Deviation	<input type="checkbox"/> BS R Diminished / Absent	
<input type="checkbox"/> R Pupil Dil / Const	<input type="checkbox"/> JVD	<input type="checkbox"/> BS L Diminished / Absent	
<input type="checkbox"/> L Pupil Dil / Const	<input type="checkbox"/>	<input type="checkbox"/> Crackles / Rales / Wheezes	
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	
CHEST		ABDOMIN	
<input type="checkbox"/> Normal		<input type="checkbox"/> Normal	
<input type="checkbox"/> DCAP-BLS		<input type="checkbox"/> DCAP-BLS	
<input type="checkbox"/> Tender RU / LU / RL / LL		<input type="checkbox"/> Tender RU / LU / RL / LL	
<input type="checkbox"/> Rigid		<input type="checkbox"/> Rigid	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
PELVIS		LOWER EXTREMITIES	
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	
<input type="checkbox"/> DCAP-BTLS	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	
<input type="checkbox"/> Crepitus	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left	
<input type="checkbox"/> Unstable	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/> PMS Deficit	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	
UPPER EXTREMITIES		BACK	
<input type="checkbox"/> Normal		<input type="checkbox"/> Normal	
<input type="checkbox"/> DCAP-BTLS Right		<input type="checkbox"/> DCAP-BTLS	
<input type="checkbox"/> DCAP-BTLS Left		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
CRITICAL INTERVENTIONS			
<input type="checkbox"/> Maintain Airway	<input type="checkbox"/> Suctioning	<input type="checkbox"/> APGAR	
<input type="checkbox"/> Spinal Immobilization	<input type="checkbox"/> Breathing Treatment	<input type="checkbox"/> Glasco Coma Scale	
<input type="checkbox"/> Ventilation	<input type="checkbox"/> Pulse Ox	<input type="checkbox"/> Oxygen LPM _____ / Delivery Device _____	
<input type="checkbox"/> Control Bleeding	<input type="checkbox"/> Glucometer Reading	<input type="checkbox"/>	
<input type="checkbox"/> CPR / Defibrillation	<input type="checkbox"/> Temperature	<input type="checkbox"/>	
<input type="checkbox"/> Other:			

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PATIENT
CONTACT

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EMT Student Patient Assessment Documentation Form

	Student Name:	WVOEMS #	Shift Date:
	Preceptor Name:	WVOEMS #	Location:
Course Instructor Name:		Started Shift:	Ended Shift:
Chief Complaint:			
DISPATCH		RACE	
<input type="checkbox"/> Non Emergency	<input type="checkbox"/> African American	<input type="checkbox"/> Scene Safe	
<input type="checkbox"/> Emergency	<input type="checkbox"/> American Indian	<input type="checkbox"/> Hazardous Materials	
GENDER	<input type="checkbox"/> Asian	<input type="checkbox"/> Violence	
<input type="checkbox"/> Male	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Traffic	
<input type="checkbox"/> Female	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Weather	
AGE:	<input type="checkbox"/> Other	<input type="checkbox"/> Electrical	
MECHANISM OF INJURY		NATURE OF ILLNESS	
<input type="checkbox"/> MVA	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Seizure	
<input type="checkbox"/> Pedestrian Struck	<input type="checkbox"/> GI	<input type="checkbox"/> OB / GYN	
<input type="checkbox"/> Fall	<input type="checkbox"/> GU	<input type="checkbox"/> Behavioral	
<input type="checkbox"/> Blunt Trauma	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Environmental	
<input type="checkbox"/> Penetrating Trauma	<input type="checkbox"/> Stroke / CVA	<input type="checkbox"/> Other:	
<input type="checkbox"/> Burn	<input type="checkbox"/> Poison / OD	<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Other:	
ASSISTANCE REQUIRED			
<input type="checkbox"/> Additional EMS			
<input type="checkbox"/> Rescue / FD			
<input type="checkbox"/> Law Enforcement			
<input type="checkbox"/> Mutual Aid			
<input type="checkbox"/> Aeromedical			
<input type="checkbox"/> Extrication			
<input type="checkbox"/> Other:			
PATIENT CONDITION			
<input type="checkbox"/> Stable			
<input type="checkbox"/> Unstable			
<input type="checkbox"/> Potentially Unstable			
<input type="checkbox"/> Critical			
<input type="checkbox"/> Full Arrest			
<input type="checkbox"/> DOS			
<input type="checkbox"/> Other:			
PRIMARY PATIENT ASSESSMENT			
LOC		AIRWAY	
<input type="checkbox"/> Alert		<input type="checkbox"/> Normal	
<input type="checkbox"/> Oriented X3		<input type="checkbox"/> Adjunct (OPA)	
<input type="checkbox"/> Verbal		<input type="checkbox"/> Combitube	
<input type="checkbox"/> Pain		<input type="checkbox"/> King Airway	
<input type="checkbox"/> Unresponsive		<input type="checkbox"/> Intubation	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
BREATHING		CIRCULATION	
<input type="checkbox"/> Normal		<input type="checkbox"/> Normal	
<input type="checkbox"/> Labored		<input type="checkbox"/> Irregular	
<input type="checkbox"/> Irregular		<input type="checkbox"/> Bounding / Weak	
<input type="checkbox"/> Deep / Shallow		<input type="checkbox"/> Rapid / Shallow	
<input type="checkbox"/> Rapid / Slow		<input type="checkbox"/> Absent Carotid/Radial	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
SKIN CONDITION			
Color:			
Temperature:			
Condition:			
Cap Refill UE: _____ Sec.			
Cap Refill LE: _____ Sec.			
<input type="checkbox"/> Other:			
FOCUSED HISTORY AND PHYSICAL EXAM			
HEAD		NECK	
<input type="checkbox"/> Normal		<input type="checkbox"/> Normal	
<input type="checkbox"/> DCAP-BLS		<input type="checkbox"/> DCAP-BLS	
<input type="checkbox"/> Fluid Nose/Ears/Mouth		<input type="checkbox"/> Tracheal Deviation	
<input type="checkbox"/> R Pupil Dil / Const		<input type="checkbox"/> JVD	
<input type="checkbox"/> L Pupil Dil / Const		<input type="checkbox"/> Crackles / Rales / Wheezes	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
CHEST		ABDOMIN	
<input type="checkbox"/> Normal		<input type="checkbox"/> Normal	
<input type="checkbox"/> DCAP-BLS		<input type="checkbox"/> DCAP-BLS	
<input type="checkbox"/> BS R Diminished / Absent		<input type="checkbox"/> Tender RU / LU / RL / LL	
<input type="checkbox"/> BS L Diminished / Absent		<input type="checkbox"/> Rigid	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
PELVIS		LOWER EXTREMITIES	
<input type="checkbox"/> Normal		<input type="checkbox"/> Normal	
<input type="checkbox"/> DCAP-BTLS		<input type="checkbox"/> DCAP-BTLS Right	
<input type="checkbox"/> Crepitus		<input type="checkbox"/> DCAP-BTLS Left	
<input type="checkbox"/> Unstable		<input type="checkbox"/> PMS Deficit	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
UPPER EXTREMITIES		BACK	
<input type="checkbox"/> Normal		<input type="checkbox"/> Normal	
<input type="checkbox"/> DCAP-BTLS Right		<input type="checkbox"/> DCAP-BTLS	
<input type="checkbox"/> DCAP-BTLS Left		<input type="checkbox"/> Other:	
<input type="checkbox"/> PMS Deficit		<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
CRITICAL INTERVENTIONS			
<input type="checkbox"/> Maintain Airway		<input type="checkbox"/> Suctioning	
<input type="checkbox"/> Spinal Immobilization		<input type="checkbox"/> Breathing Treatment	
<input type="checkbox"/> Ventilation		<input type="checkbox"/> Pulse Ox	
<input type="checkbox"/> Control Bleeding		<input type="checkbox"/> Glucometer Reading	
<input type="checkbox"/> CPR / Defibrillation		<input type="checkbox"/> Temperature	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	

WEST VIRGINIA OFFICE OF EMERGENCY MEDICAL SERVICES
EMT Student Patient Assessment Documentation Form


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Students may test National Registry prior to completing the required 10 patient contacts by utilizing this packet and submitting it to WVOEMS. This education relief may ONLY be utilized during the COVID-19 policy modification and only applies to EMT courses ending prior to July 1, 2020. Submit to: Jerry.L.Mullins@wv.gov

PATIENT
CONTACT

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EMT Student Patient Assessment Documentation Form

	Student Name:		WVOEMS #		Shift Date:	
	Preceptor Name:		WVOEMS #		Location:	
Course Instructor Name:			Started Shift:		Ended Shift:	
Chief Complaint:						
DISPATCH		RACE		SCENE SURVEY		
<input type="checkbox"/> Non Emergency	<input type="checkbox"/> African American	<input type="checkbox"/> Scene Safe	<input type="checkbox"/> Drowning			
<input type="checkbox"/> Emergency	<input type="checkbox"/> American Indian	<input type="checkbox"/> Hazardous Materials	<input type="checkbox"/> Explosion			
GENDER	<input type="checkbox"/> Asian	<input type="checkbox"/> Violence	<input type="checkbox"/> Other:			
<input type="checkbox"/> Male	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Traffic				
<input type="checkbox"/> Female	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Weather				
AGE:	<input type="checkbox"/> Other	<input type="checkbox"/> Electrical				
MECHANISM OF INJURY		NATURE OF ILLNESS		ASSISTANCE REQUIRED		PATIENT CONDITION
<input type="checkbox"/> MVA	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Seizure	<input type="checkbox"/> Additional EMS	<input type="checkbox"/> Stable		
<input type="checkbox"/> Pedestrian Struck	<input type="checkbox"/> GI	<input type="checkbox"/> OB / GYN	<input type="checkbox"/> Rescue / FD	<input type="checkbox"/> Unstable		
<input type="checkbox"/> Fall	<input type="checkbox"/> GU	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Potentially Unstable		
<input type="checkbox"/> Blunt Trauma	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Environmental	<input type="checkbox"/> Mutual Aid	<input type="checkbox"/> Critical		
<input type="checkbox"/> Penetrating Trauma	<input type="checkbox"/> Stroke / CVA	<input type="checkbox"/> Other:	<input type="checkbox"/> Aeromedical	<input type="checkbox"/> Full Arrest		
<input type="checkbox"/> Burn	<input type="checkbox"/> Poison / OD		<input type="checkbox"/> Extrication	<input type="checkbox"/> DOS		
<input type="checkbox"/> Other:	<input type="checkbox"/> Anaphylaxis		<input type="checkbox"/> Other:			
PRIMARY PATIENT ASSESSMENT						
LOC	AIRWAY	BREATHING	CIRCULATION	SKIN CONDITION		
<input type="checkbox"/> Alert	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	Color:		
<input type="checkbox"/> Oriented X3	<input type="checkbox"/> Adjunct (OPA)	<input type="checkbox"/> Labored	<input type="checkbox"/> Irregular	Temperature:		
<input type="checkbox"/> Verbal	<input type="checkbox"/> Combitube	<input type="checkbox"/> Irregular	<input type="checkbox"/> Bounding / Weak	Condition:		
<input type="checkbox"/> Pain	<input type="checkbox"/> King Airway	<input type="checkbox"/> Deep / Shallow	<input type="checkbox"/> Rapid / Shallow	Cap Refill UE: _____ Sec.		
<input type="checkbox"/> Unresponsive	<input type="checkbox"/> Intubation	<input type="checkbox"/> Rapid / Slow	<input type="checkbox"/> Absent Carotid/Radial	Cap Refill LE: _____ Sec.		
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:		
FOCUSED HISTORY AND PHYSICAL EXAM						
HEAD		NECK		CHEST		ABDOMIN
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal		
<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS		
<input type="checkbox"/> Fluid Nose/Ears/Mouth	<input type="checkbox"/> Tracheal Deviation	<input type="checkbox"/> BS R Diminished / Absent	<input type="checkbox"/> BS L Diminished / Absent	<input type="checkbox"/> Tender RU / LU / RL / LL		
<input type="checkbox"/> R Pupil Dil / Const	<input type="checkbox"/> JVD	<input type="checkbox"/> Crackles / Rales / Wheezes	<input type="checkbox"/> Rigid			
<input type="checkbox"/> L Pupil Dil / Const		<input type="checkbox"/> Other:	<input type="checkbox"/> Other:			
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:			
PELVIS		LOWER EXTREMITIES		UPPER EXTREMITIES		BACK
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal		
<input type="checkbox"/> DCAP-BTLS	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS		
<input type="checkbox"/> Crepitus	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/>		
<input type="checkbox"/> Unstable	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:		
CRITICAL INTERVENTIONS						
<input type="checkbox"/> Maintain Airway	<input type="checkbox"/> Suctioning	<input type="checkbox"/> APGAR				
<input type="checkbox"/> Spinal Immobilization	<input type="checkbox"/> Breathing Treatment	<input type="checkbox"/> Glasco Coma Scale				
<input type="checkbox"/> Ventilation	<input type="checkbox"/> Pulse Ox	<input type="checkbox"/> Oxygen LPM _____ / Delivery Device _____				
<input type="checkbox"/> Control Bleeding	<input type="checkbox"/> Glucometer Reading	<input type="checkbox"/>				
<input type="checkbox"/> CPR / Defibrillation	<input type="checkbox"/> Temperature	<input type="checkbox"/>				
<input type="checkbox"/> Other:						

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